August 28, 2002

Re: Medical Dispute Resolution
MDR #: M2-02-0948-01
IRO Certificate No.: IRO 5055

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician Board Certified in Chiropractic Medicine.

The reviewer DISAGREES with the determination made by the insurance carrier in this case. The reviewer is of the opinion that a multi-disciplinary pain management program for five (5) days a week for six (6) weeks at eight (8) hours per day is medically necessary in this case.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **ten (10)** days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **twenty (20)** days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5)** days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 28TH day of August 2002.

Sincerely,

MEDICAL CASE REVIEW

This is for ___. I have reviewed the medical information forwarded to me concerning MDR #M2-02-0948-01, in the area of Chiropractic Care and Pain Management. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Medical Dispute Resolution Request/Response.
2. Table of Disputed Services.
3. ___ position letter.
4. Letter of medical necessity by ___.
5. Appeal letter dated 5/02/02 by ___.
6. Letters of denial for chronic pain management program by ___, dated 6/28/02, 5/14/02, 5/17/02 and 5/28/02.
7. Records which included, but are not limited to, initial evaluations, office notes, treatment notes, FCE's, MRI, EMG, therapy notes, Orthopedic consultation, x-ray reports, behavioral medicine evaluation, and work hardening notes (total pages, 187).

B. BRIEF CLINICAL HISTORY:

The patient was injured on the job on ___. A treatment program was instituted by ___, her treating doctor. Over the course of treatment, she has received primary and secondary conservative care for this injury.

C. DISPUTED SERVICES:

Multi-disciplinary chronic pain management program for five days a week for six weeks at eight hours a day. Program to include vocational counseling, biofeedback, individual psychotherapy, group psychotherapy, physical therapy, and education.

D. DECISION:

I DISAGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE.

E. RATIONALE OR BASIS FOR DECISION:

Review of the records indicates the patient has been treated with chiropractic manipulation, physical therapy, hot and cold packs, electric stimulation, ultrasound, myofascial release, massage, pain medication, and therapeutic exercises. The patient also had two ESI injections which provided short-term pain relief. The third injection was denied three times by the previous insurance carrier, ___, because, in their opinion, the patient was not benefitting from the previous two injections. In addition, the patient completed a work hardening program on 3/12/02.

Records further indicate the patient does not appear to have a surgical correctable lesion and, therefore, is not a surgical candidate. The patient has developed a chronic pain syndrome secondary to her work-related injury.

Furthermore, the patient was referred for a psychological pain evaluation which indicated she was an ideal candidate for participation in an interdisciplinary chronic pain management program.

It is my opinion that all records and reports contained in these notes document the need for this patient to participate in an interdisciplinary chronic pain management program. The justification for this is that this patient's injury and current condition falls within the *American Medical Association Treatment Guidelines for Chronic Pain*, as well as the recent Intracorp treatment guidelines for chronic pain.

In summary, under TWCC Rule 180.22, the healthcare provider is expected to provide reasonable and necessary healthcare that: cures or relieves the effects naturally resulting from the compensable injury; promotes recovery; and/or enhances the ability of the employee to return to work or retain employment.

Based upon the review of all supplied records, and according to the patient's treating doctor and numerous other healthcare providers from a variety of disciplines, it is my opinion an interdisciplinary pain management program for this patient is reasonable and necessary and needs to be instituted as soon as possible.

F. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 27 August 2002